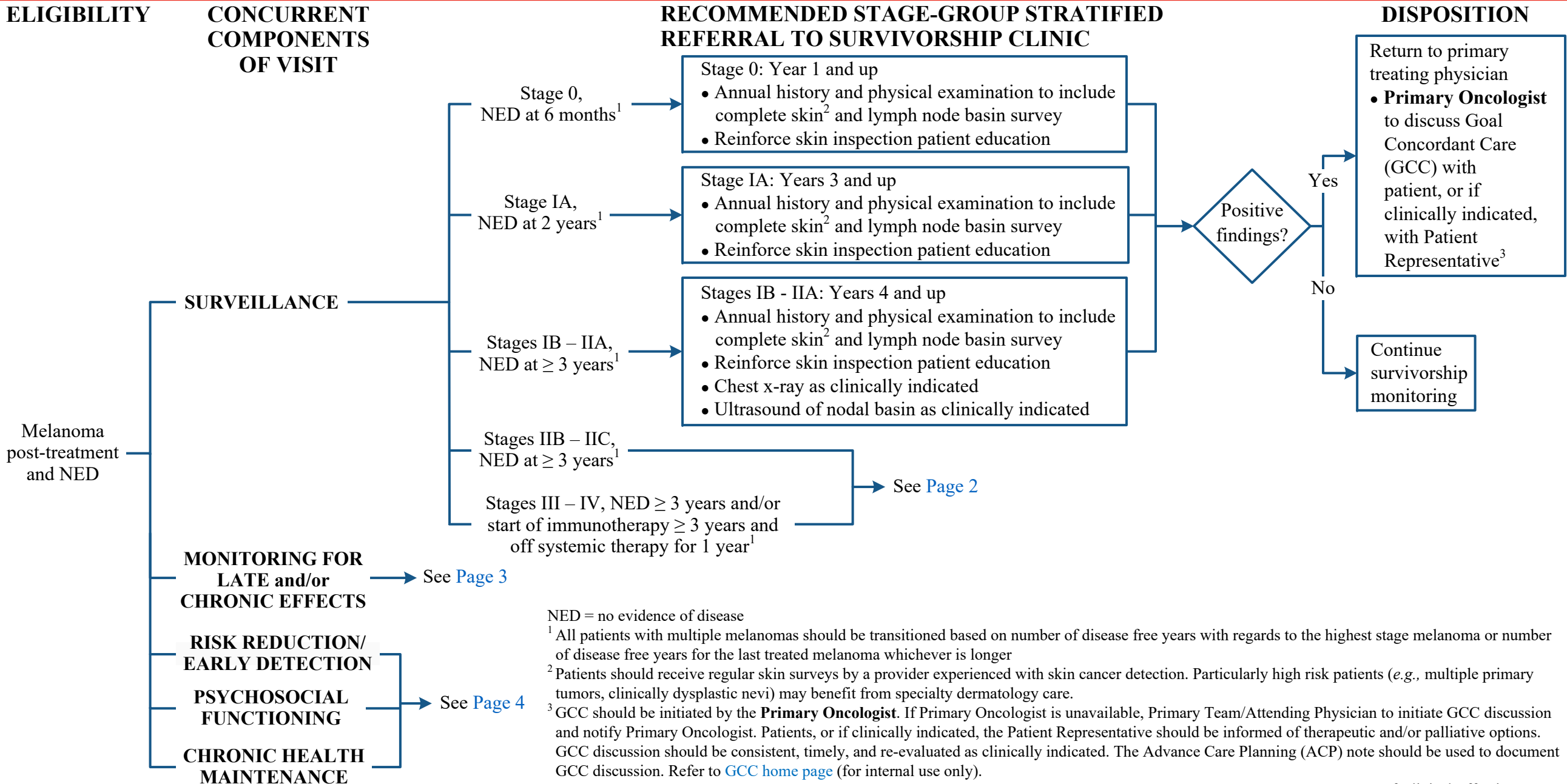


Disclaimer: This algorithm has been developed for UT MD Anderson using a multidisciplinary approach considering circumstances particular to UT MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.



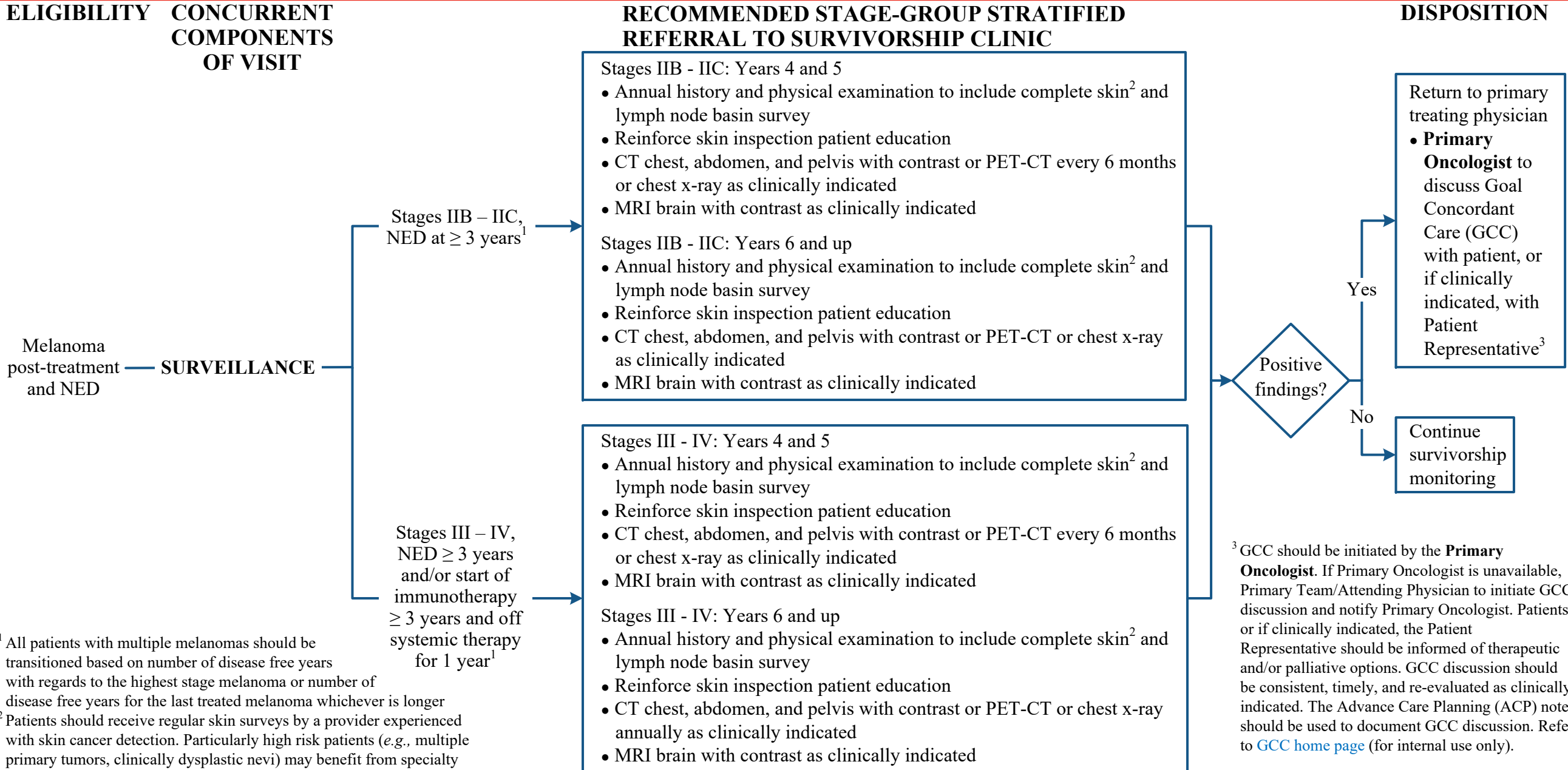
NED = no evidence of disease

¹ All patients with multiple melanomas should be transitioned based on number of disease free years with regards to the highest stage melanoma or number of disease free years for the last treated melanoma whichever is longer

² Patients should receive regular skin surveys by a provider experienced with skin cancer detection. Particularly high risk patients (e.g., multiple primary tumors, clinically dysplastic nevi) may benefit from specialty dermatology care.

³ GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to [GCC home page](#) (for internal use only).

Disclaimer: This algorithm has been developed for UT MD Anderson using a multidisciplinary approach considering circumstances particular to UT MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.



¹ All patients with multiple melanomas should be transitioned based on number of disease free years with regards to the highest stage melanoma or number of disease free years for the last treated melanoma whichever is longer

² Patients should receive regular skin surveys by a provider experienced with skin cancer detection. Particularly high risk patients (e.g., multiple primary tumors, clinically dysplastic nevi) may benefit from specialty dermatology care.

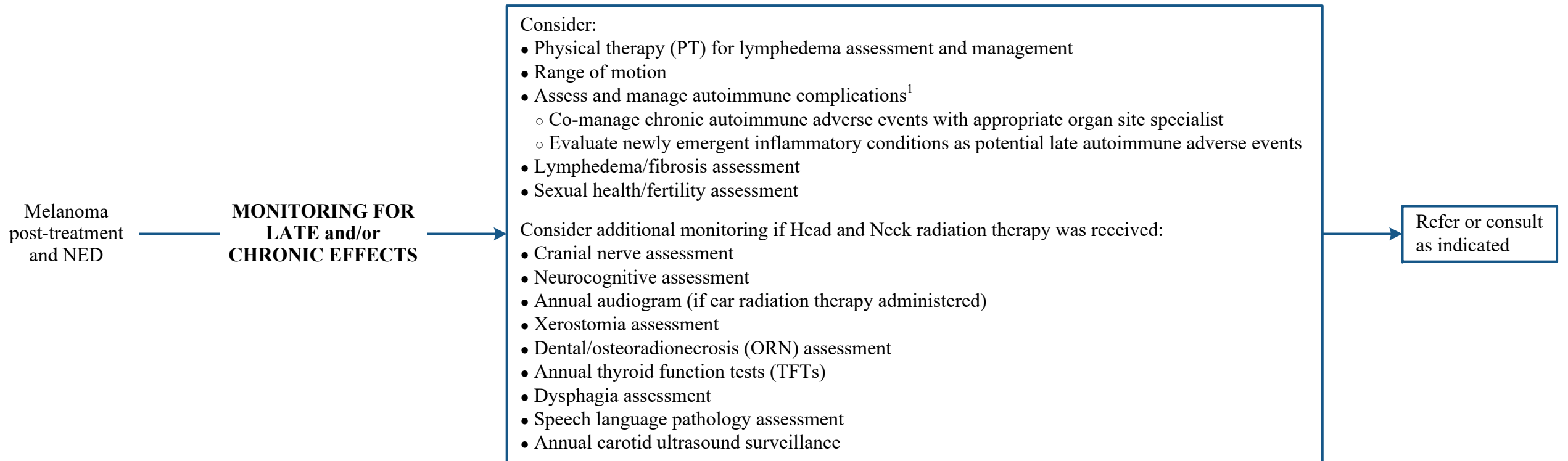
³ GCC should be initiated by the **Primary Oncologist**. If Primary Oncologist is unavailable, Primary Team/Attending Physician to initiate GCC discussion and notify Primary Oncologist. Patients, or if clinically indicated, the Patient Representative should be informed of therapeutic and/or palliative options. GCC discussion should be consistent, timely, and re-evaluated as clinically indicated. The Advance Care Planning (ACP) note should be used to document GCC discussion. Refer to [GCC home page](#) (for internal use only).

Disclaimer: This algorithm has been developed for UT MD Anderson using a multidisciplinary approach considering circumstances particular to UT MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

ELIGIBILITY

CONCURRENT COMPONENTS OF VISIT

DISPOSITION



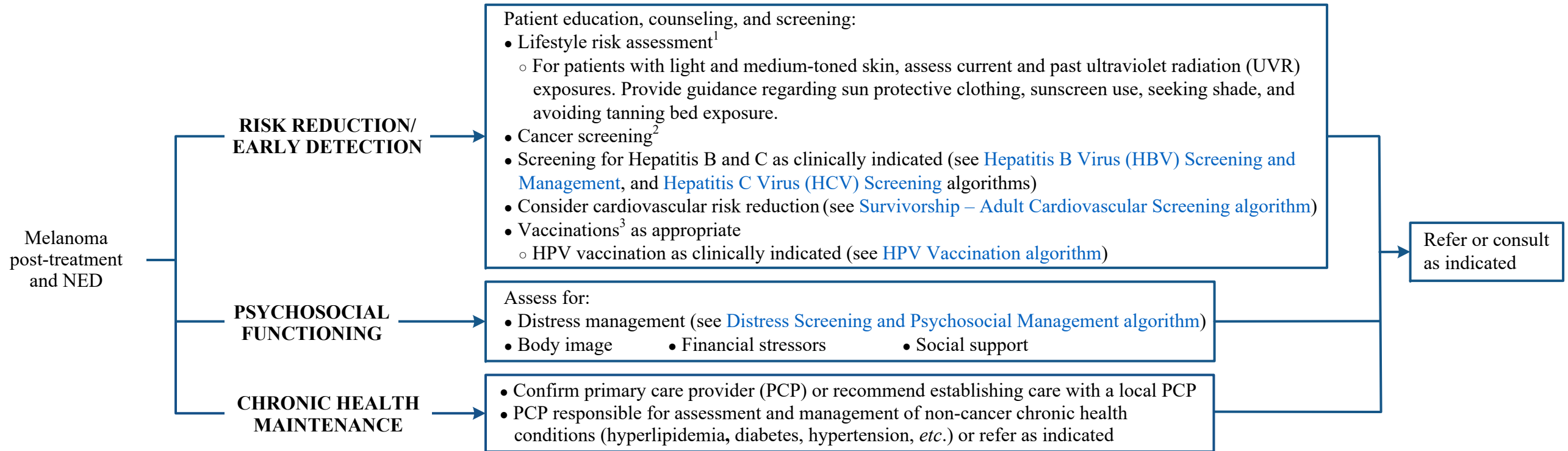
¹ Though most immune-related adverse events (irAEs) occur while on immunotherapy, some irAEs can manifest late and/or treatment-emergent irAEs may become chronic. Endocrine organ irAEs (*i.e.* hypothyroidism, adrenal insufficiency, Type 1 Diabetes Mellitus) are permanent and must be treated with life-long hormonal replacement with appropriate monitoring. Other irAEs, most commonly rheumatological or neurological, may be chronic or relapsing/remitting and require chronic immunosuppression. These chronic irAEs should be co-managed with appropriate organ site specialist. Thyroid function should be monitored annually in patients with immunotherapy exposure and the possibility of late irAEs considered for new inflammatory issues.

Disclaimer: This algorithm has been developed for UT MD Anderson using a multidisciplinary approach considering circumstances particular to UT MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

ELIGIBILITY

CONCURRENT COMPONENTS OF VISIT

DISPOSITION



¹ See [Physical Activity](#), [Nutrition](#), [Obesity Screening and Management](#), and [Tobacco Cessation Treatment](#) algorithms; ongoing reassessment of lifestyle risks should be a part of routine clinical practice

² Includes breast, cervical, colorectal, liver, lung, pancreatic, prostate, and skin cancer screening

³ Based on [American Society of Clinical Oncology \(ASCO\) guidelines](#)

Disclaimer: This algorithm has been developed for UT MD Anderson using a multidisciplinary approach considering circumstances particular to UT MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

SUGGESTED READINGS

- Amaral, T., Ottaviano, M., Arance, A., Blank, C., Chiarion-Sileni, V., Donia, M., ... ESMO Guidelines Committee. (2025). Cutaneous melanoma: ESMO clinical practice guideline for diagnosis, treatment and follow-up. *Annals of Oncology*, 36(1), 10-30. doi:10.1016/j.annonc.2024.11.006
- Boland, G. M., & Gershenwald, J. E. (2015). Melanoma Survivorship Management. *Advances in Cancer Survivorship Management* (pp. 219-239). New York, NY: Springer.
- Brown, R. E., Stromberg, A. J., Hagendoorn, L. J., Hulsewede, D. Y., Ross, M. I., Noyes, R. D., ... Martin, R. C. G. (2010). Surveillance after surgical treatment of melanoma: Futility of routine chest radiography. *Surgery*, 148(4), 711-717. doi:10.1016/j.surg.2010.07.042
- Francken, A. B., Accortt, N. A., Shaw, H. M., Colman, M. H., Wiener, M., Soong, S. J., ... Thompson, J. F. (2008). Follow-up schedules after treatment for malignant melanoma. *British Journal of Surgery*, 95(11), 1401-1407. doi:10.1002/bjs.6347
- Gamble, R. G., Jensen, D., Suarez, A. L., Hanson, A. H., McLaughlin, L., Duke, J., & Dellavalle, R. P. (2010). Outpatient follow-up and secondary prevention for melanoma patients. *Cancers*, 2(2), 1178-1197. doi:10.3390/cancers2021178
- Kamboj, M., Bohlke, K., Baptiste, D. M., Dunleavy, K., Fueger, A., Jones, L., ... Kohn, E. C. (2024). Vaccination of adults with cancer: ASCO guideline. *Journal of Clinical Oncology*, 42(14), 1699-1721. doi:10.1200/JCO.24.00032
- Leiter, U., Eigentler, T. K., Forschner, A., Pflugfelder, A., Weide, B., Held, L., ... Garbe, C. (2010). Excision guidelines and follow-up strategies in cutaneous melanoma: Facts and controversies. *Clinics in Dermatology*, 28(3), 311-315. doi:10.1016/j.clindermatol.2009.10.001
- National Cancer Institute, Division of Cancer Control and Population Sciences. (2025). *National Standards for Cancer Survivorship Care*. Retrieved from <https://cancercontrol.cancer.gov/ocs/special-focus-areas/national-standards-cancer-survivorship-care>
- National Comprehensive Cancer Network. (2026). *Melanoma: Cutaneous* (NCCN Guideline Version 1.2026). Retrieved from https://www.nccn.org/professionals/physician_gls/pdf/cutaneous_melanoma.pdf
- Romano, E., Scordo, M., Dusza, S. W., Coit, D. G., & Chapman, P. B. (2010). Site and timing of first relapse in stage III melanoma patients: Implications for follow-up guidelines. *Journal of Clinical Oncology*, 28(18), 3042-3047. doi:10.1200/JCO.2009.26.2063
- Speijers, M. J., Francken, A. B., Hoekstra-Weebers, J. E., Bastiaannet, E., Kruijff, S., & Hoekstra, H. J. (2010). Optimal follow-up for melanoma. *Expert Review of Dermatology*, 5(4), 461-478. doi:10.1586/edm.10.38
- UT MD Anderson Institutional Policy #CLN1202 - Advance Care Planning Policy
Advance Care Planning (ACP) Conversation Workflow (ATT1925)

Disclaimer: This algorithm has been developed for UT MD Anderson using a multidisciplinary approach considering circumstances particular to UT MD Anderson's specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient's care. This algorithm should not be used to treat pregnant women.

DEVELOPMENT CREDITS

This survivorship algorithm is based on majority expert opinion of the Melanoma Survivorship workgroup at The University of Texas MD Anderson Cancer Center. It was developed using a multidisciplinary approach that included input from the following:

Core Development Team Leads

Ashleigh Francis, MD (Plastic Surgery)
Jeffrey E. Gershenwald, MD (Surgical Oncology)
Katherine Gilmore, MPH (Cancer Survivorship)
Madison LaRose, MSN, APRN (Surgical Oncology)
Kelly Nelson, MD (Dermatology)
Michelle Rohlf, DNP, APRN, FNP-BC, AOCNP (Melanoma Medical Oncology)
Shirley Su, MBBS FRACS (Head and Neck Surgery)

Workgroup Members

Olga N. Fleckenstein, BS[♦]
Ryan Goepfert, MD (Head and Neck Surgery)
Brittnee Macintyre, MSN, APRN, FNP-C[♦]
Brandon McAnulty, DNP, APRN, AGACNP-BC, RNFA (Head & Neck Surgery)
Jeffrey N. Myers, MD, PhD (Head and Neck Surgery)
Kristen Pytynia, MD (Head and Neck Surgery)
Johnny L. Rollins, MSN, APRN, ANP-C (Cancer Survivorship)
Merrick Ross, MD (Surgical Oncology)
Hussein Tawbi, MD, PhD (Melanoma Medical Oncology)
Mark Zafereo, MD (Head and Neck Surgery)

[♦]Clinical Effectiveness Development Team